Enrollment Application
Group size 51+ eligible employees

Anthem BlueCross BlueShield

Community Insurance Company

AnthemLife

INSTRUCTIONS:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer.

Section 1: Employer/Group Use — Required

Employer name		Employer address		
Group no.	Sub-group no./Life division no.	Requested effective date	Life classification	Employee no./Dept. name

Section 2: Reason for Application — Required

☐ New enrollment ☐ New hire ☐ Add dependent (Fill in Section 3)
☐ Annual open enrollment (N/A to Life) ☐ Rehire – Date: ____
☐ COBRA – Qualifying event: _____ COBRA event date: ____
☐ Waiver (To decline ALL coverage skip to Section 12)

Section 3: Status Change/Event — Required, if you checked "Add dependent" option in Section 2.

Event date	☐ Marriage ☐ Birth ☐ Adoption (Attach legal documentation) ☐ Legal guardianship (Attach legal documentation) ☐ Loss of coverage (reason): _____ ☐ Terminated employment ☐ Other: _____

Section 4: Plan/Type of Coverage — Required. To decline a plan type, check "No coverage". If you are waiving all coverage, go to Section 12.

Medical — If multiple Medical plans are available, please indicate the plan type below and write plan number in the space provided.

☐ HMO
☐ POS
☐ PPO
☐ Blue Priority℠ (a health insuring corporation product or "HIC")
☐ Blue Traditional
☐ Anthem Essential℠ PPO
☐ Lumenos® HSA PPO[1]
☐ Lumenos® HRA PPO
☐ Lumenos® HIA PPO
☐ Lumenos® Health Incentive Account Plus PPO
☐ Lumenos® Deductible First HRA PPO

If multiple Medical plans are available, write plan number: _____

Type of medical coverage: ☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

Dental — To apply for BUY-UP coverage, check PPO and write in the plan number on the line provided.

☐ PPO: _____
☐ Traditional
☐ Dental Blue®100/200/300
☐ Dental Blue® 100
☐ Dental Prime & Dental Complete If elected, we need the following filled out:
Dental group no.: _____ Dental subgroup: _____ Group representative phone no.: _____
Have you had dental coverage in the past? ☐ Yes ☐ No
If yes, when did coverage start? _____ When did coverage end? _____
Previous insurance carrier's name: _____ What was your policy number? _____

Type of dental coverage: ☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

Vision

Type of vision coverage: ☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

Life

Fill in Section 7.

Section 5: Employee Information — Required

Last name	First name	M.I.	Social Security no.[2] (required)

Date of birth	Age	Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Divorced	Height	Weight

Home phone no.	Business phone no.	Email address

Street address	City	State	ZIP code	County

Retired? ☐ Yes ☐ No Disabled? ☐ Yes ☐ No Hospitalized? ☐ Yes ☐ No	Occupation	Hours working per week	Full-time hire date	Income reported by: ☐ W-2 ☐ 1099 ☐ Other: _____

1 Anthem will facilitate the opening of a Health Savings Account (HSA) in your name, if directed by your employer.
2 Anthem is required by the Internal Revenue Service to collect this information.

Employee name	Social Security no.* (required)

Section 6: Family Information — Required. List only dependents you wish to enroll, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 10, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 6.

Spouse/Domestic Partner

Last name	First name	M.I.	Social Security no.* (required)

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled?
			☐ M ☐ F	☐ Spouse ☐ Domestic Partner	☐ Yes ☐ No If yes, give reason:

If spouse/DP address is different than employee, please provide full address

Dependent

Last name	First name	M.I.	Social Security no.* (required)	Full-time student?
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled?
			☐ M ☐ F	☐ Child ☐ Other:	☐ Yes ☐ No If yes, give reason:

Court ordered health care coverage? ☐ Yes ☐ No (If yes,attach legal documentation)

If dependent address is different than employee, please provide full address

Dependent

Last name	First name	M.I.	Social Security no.* (required)	Full-time student?
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled?
			☐ M ☐ F	☐ Child ☐ Other:	☐ Yes ☐ No If yes, give reason:

Court ordered health care coverage? ☐ Yes ☐ No (If yes, attach legal documentation)

If dependent address is different than employee, please provide full address

Section 7: Life and Disability Insurance — Required, if this type of coverage was selected in Section 4.

Current Income: $_____ ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Life Class

☐ Basic Life ☐ Optional Life: _____ x Annual Earnings ☐ Basic AD&D ☐ Short-Term Disability: _____
☐ Dependent Life OR $_____ ☐ Optional AD&D ☐ Long-Term Disability: _____

Anthem ByDesign Buy-Up. Check appropriate box and write in the percentage next to the benefit selected. Complete separate election form.

☐ Short-Term Disability: _____% ☐ Long-Term Disability: _____% ☐ Basic Life

Primary beneficiary

Last name	First name	M.I.	Social Security no.* (required)	Relationship to employee	Age

Contingent beneficiary

Last name	First name	M.I.	Social Security no.* (required)	Relationship to employee	Age

Section 8: Other Health Coverage — Required

Do you and/or your dependents have other health coverage? ☐ Yes ☐ No If yes, complete below.

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage?

Provide name, phone number and address of the HMO or insurance company	Policy/certificate no.	Effective date

Policy/certificate holder name	Social Security no.* (required)	Date of birth	Relationship to employee

Are you and/or your dependents enrolled in Medicare or Medicaid? ☐ Yes ☐ No If yes, complete below.

Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date

Medicare Part D ID no.	Medicare Part D carrier	Medicare Part D effective date	Medicare Part D term date

Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

*Anthem is required by the Internal Revenue Service to collect this information.

Employee name	Social Security no.* (required)

Have you and/or your dependents had prior health coverage? ☐ Yes ☐ No If yes, complete below.			
Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No	Policy/certificate no.		
Group name/ID no.		Date policy in effect	Date policy termed
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No			
List prior carrier(s)		Date policy in effect	Date policy termed
Please check the type of prior coverage ☐ Employee ☐ Employee+Spouse/DP ☐ Employee+Child(ren) ☐ Employee+Spouse/DP+Child(ren)			
Termination reason: ☐ Divorce/legal separation ☐ Employment terminated ☐ Employer/group contribution ceased ☐ Other ☐ Death of spouse/DP ☐ COBRA coverage exhausted ☐ Group plan terminated			

Section 9: Significant Terms, Conditions and Authorizations (TERMS) — Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

1. I understand that I may not assign any payment under my Community Insurance Company (Anthem) program, unless allowable by law.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
5. If applying for HIC/HMO coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.
7. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 CFR. Parts 160 & 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

I certify each Social Security Number listed on this application is correct.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 10: Signature — Required, if you are applying for coverage. Please review your application for errors or omissions.

Read Section 10 carefully before signing.
I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature	Date
X	

*Anthem is required by the Internal Revenue Service to collect this information.

Employee name	Social Security no.* (required)

Section 11: Waiver of coverage — Complete for yourself and/or any eligible dependents. Check all that apply.

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
☐ **Medical**	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ **Dental**	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ **Vision**	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ **Life**	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ **All**	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	

Check all that apply:

☐ I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such coverage at a later date, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse or domestic partner) because of other health insurance coverage, provided that enrollment is requested within 31 days after other coverage ends. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

☐ I have been given an opportunity to apply for the available group life benefits offered by my employer/group. The benefits have been explained to me, and I and/or my dependent(s) decline to participate. My dependent(s) or I were not induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for coverage in the future, I may be required to provide evidence of insurability at my expense.

Signature — Required, if you want to waive coverage for yourself and your dependents.

Employee signature **X**	Date

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